



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: STAT 2000 P O BOX 15640 FORT WORTH TX 76119	MFDR Tracking #: M4-05-0459-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TRAVELERS INDEMNITY COMPANY Box #: 05	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from Request for Reconsideration Letter dated 02/11/04: "...you have denied payment for the monthly rental of the neuromuscular stimulator stating that the E1399 code we are using is not valid. Please see all the documentation which supports our claim and that the code is valid and please process our claims for payment due. Medicare does allow for use of HCPCS E1399 miscellaneous code when no other descriptive coding is available providing that an adequate description is given of the product. The NT-2000 is a combo unit and is properly coded and described on the claim form. In accordance with TWCC guidelines Subchapter C-Medical Fee Guidelines. Section 134.202(c)(2), in paraphrase says that if Medicare and Medicaid do not have a fee schedule for a code then values will be established based in part on commission medical dispute decision. There have been innumerable decisions upholding \$250/month rental."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Copy of Manufacturer's Product Documentation of BMR NT2000 Neuromuscular Electrical Stimulator
5. Total Amount Sought - \$490.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The rationale for denial is based on the codes the provider is using. There is a valid HCPC code and per TWCC billing for DME/supplies should be in compliance with medicaid/medicare [sic] coding guidelines."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/15/2003	E1399-One month rental BMR NT2000 Neuromuscular Electrical Stimulator	N/A	\$245.00	\$0.00
10/15/2003	E1399-One month rental BMR NT2000 Neuromuscular Electrical Stimulator	N/A	\$245.00	\$0.00
Total Due:				\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on September 14, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 17, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Explanation of benefits dated 10/31/2003
 - TR21-N-The fee schedule does not allow reimbursement for non valid codes. Please resubmit using the correct CPT code.
 - Explanation of benefits dated 11/20/2003
 - TR21-N-The fee schedule does not allow reimbursement for non valid codes. Please resubmit using the correct CPT code.
 - Explanation of benefits dated 12/03/2003
 - TR21-N-The fee schedule does not allow reimbursement for non valid codes. Please resubmit using the correct CPT code.
 - Explanation of benefits dated 12/24/2003
 - TR10-N-Please provide CPT codes for all services rendered.
 - Explanation of benefits dated 12/29/2003
 - TR10-N-Please provide CPT codes for all services rendered.
 - Explanation of benefits dated 02/26/2004
 - NSUB-After carefully reviewing the resubmitted invoice, additional reimbursement is not justified.
 - Explanation of benefits dated 02/28/2004
 - TR10-N-Please provide CPT codes for all services rendered.

Issues

1. Are the denial codes supported?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied disputed services using codes TR21-N "The fee schedule does not allow reimbursement for non valid codes. Please resubmit using the correct CPT code"; TR10-N "Please provide CPT codes for all services rendered." The provider billed the disputed service with HCPCS code E1399. The division notes that E1399 is a valid HCPCS code described as "Durable medical equipment, miscellaneous" that may be used with supporting documentation to bill for items for which a more specific code is unavailable. Review of the submitted documentation finds that:
 - Documentation submitted by the respondent states that "DB-RSUB DENIED E1399 IS VALID CODE HOWEVER PROVIDER IS BILLING FOR NEUROMUSCULAR STIMULATOR WHICH HAS A VALID HCPC CODE SUCH AS E0744 AND E0745. E1399 IS TO BE USED WHEN NO OTHER CODE DESCRIBES UNITS, IN THIS CASE THERE IS A VALID HCPC CODE AND PER TWCC BILLING FOR DME/SUPPLIES SHOULD BE IN COMPLIANCE

WITH MEDICAID/MEDICARE CODING GUIDELINES RSUB DONE TY" [SIC].

- The Division notes that code E0744 is described as a "neuromuscular stimulator for scoliosis." No documentation was submitted to support that the disputed service was intended for the treatment of scoliosis. Nor did the respondent present any documentation to support that E0744 is a more accurate code to describe the disputed service.
- The Division further notes that E0745 is described as a "Neuromuscular stimulator, electronic shock unit." No documentation was submitted to support that E0745 is a more accurate code to describe the dispute service.
- The requestor submitted documentation to support that E0745 is not an applicable code for the service in dispute and additionally to support the E11399 is the most appropriate code for the disputed service.

The Division concludes that the denial codes used by the carrier are not supported. The disputed services will be reviewed according to applicable Division rules and guidelines.

2. Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection." HCPCS code E1399 is described as "Durable Medical Equipment, miscellaneous". The requestor noted on medical bills that HCPCS code E1399 was for a "NT 2000 Muscle Stimulator Rent." Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has a set fee for HCPCS code E1399.

Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that HCPCS code E1399 does not have an established relative value or payment amount and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS code E1399; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

3. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "There have been innumerable decisions upholding \$150/month rental."
 - The requestor did not submit citations to or copies of Division decisions upholding \$150/month rental.
 - The requestor did not submit documentation to support that payment of \$150/month rental would result in a fair and reasonable rate of reimbursement.
 - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Medical Fee Dispute Resolution Officer

June 30, 2010

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.